STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445124	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BRANDYWOOD	555 E BLEDSOE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Federal Monitoring Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities survey on 11/07/16. During this Federal Monitoring Survey, Golden Living Center of Brandywood was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2000. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=D	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.	K 324		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445124	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BRANDYWOOD	555 E BLEDSOE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 1 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based on document review, the facility failed to maintain the cooking facilities. The findings included: 1. Document review on 11/7/16 at 10:17 AM, revealed the facility failed to provide the documentation for the semi annual hood suppression inspection. (last conducted on 1/16). NFPA 101, 19.3.2.5.3 (2012 Edition) NFPA 96, 11.2.1 (2011 Edition). 2. Document review on 11/7/16 at 10:18 AM, revealed the facility failed to provide the documentation for the semi annual hood cleaning. (last conducted on 3/16). NFPA 101, 19.3.2.5.3 (2012 Edition), NFPA 96, 11.4 (2011 Edition) The Maintenance Director and the Director of Nursing were present when the deficiencies were identified and were acknowledged by the Administrator during the exit conference on 11/7/16.	K 324	K 324 1. No residents were found to be affected. 2. The facility has determined that all residents have the potential to be affected. 3. Averus scheduled to perform semi annual hood suppression inspection and semi annual hood cleaning on 11.22.2016. 4. The Maintenance Director, or designee, will complete 2017 calendar to schedule all required tests and cleaning. To ensure all cleaning and inspections occur, calendar will be reviewed monthly at Quality Assurance meeting until consistent substantial compliance has been met, or a minimum of three months.	12.15.16
K 341 SS=D	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to	K 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445124	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BRANDYWOOD	555 E BLEDSOE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 341	Continued From page 2 provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the fire alarm system. The findings included: Observation on 11/7/16 at 9:05 AM, revealed the smoke detector in the 400 hall was less then 3 feet from the air diffuser. NFPA 101, 19.3.4.5.1 (2012 Edition), NFPA 101, 9.6.1.3 (2012 Edition), NFPA 72, 17.7.4.1 (2009 Edition). The Maintenance Director and the Director of Nursing were present when the deficiencies were identified and were acknowledged by the Administrator during the exit conference on 11/7/16.	K 341	K 341 1. No residents were found to be affected. 2. The facility has determined that all residents have the potential to be affected. 3. International Fire scheduled to move smoke detector on 400 hall. 4. The Maintenance Director, or designee, will monitor smoke detector locations in daily rounds. Rounds will be documented daily, , deficiencies will be reviewed monthly at Quality Assurance meeting until consistent substantial compliance has been met, or a minimum of three months.	12.15.16
K 345 SS=D	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm	K 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445124	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BRANDYWOOD	555 E BLEDSOE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 3 and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on document review, the facility failed to maintain the fire alarm system. The findings included: Document review on 11/7/16 at 10:08 AM, revealed the facility failed to provide the annual fire alarm testing documentation for 2016 (2015 inspection conducted April 2015). NFPA 101, 19.3.4.5.1 (2012 Edition) NFPA 101, 9.6.1.3 (2012 Edition), NFPA 72, 14.4.5 (2009 Edition). The Maintenance Director and the Director of Nursing were present when the deficiencies were identified and were acknowledged by the Administrator during the exit conference on 11/7/16.	K 345	K 345 1. No residents were found to be affected. 2. The facility has determined that all residents have the potential to be affected. 3. The annual fire alarm testing was completed on April 28, 2016. 4. The Maintenance Director, or designee, will schedule on 2017 calendar. Noncompliance will be reviewed monthly at Quality Assurance meeting until consistent substantial compliance has been met, or a minimum of three months. 12.15.16	
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445124	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BRANDYWOOD	555 E BLEDSOE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 4 available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observations and document review, the facility failed to maintain the sprinkler system. The findings included: 1. Observation on 11/7/16 at 9:15 AM, revealed storage within 18 inches of a sprinkler in the following locations: a. Room 407 b. Room 411 NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, 9.7.1.1 (2012 Edition), NFPA 13, 8.5.6.1 (2010 Edition). 2. Observation on 11/7/16 at 9:30 AM, revealed the sprinklers were corroded in the following areas: a. 500 Hall Shower Room (2 of 3) b. Kitchen walk in cooler c. Kitchen Washing area (2 of 2) NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, 9.7.1.1 (2012 Edition), NFPA 13, 26.1 (2010 Edition), NFPA 25, 5.2.1.1.2 (2011 Edition) 3. Observations on 11/7/16 at 9:35 AM, revealed the sprinkler was damaged outside the chemical storage room door.	K 353	K 353 1. No residents were found to be affected. 2. The facility has determined that all residents have the potential to be affected. 3. Items in rooms 407 and 411 were immediately moved. Sprinklers were all replaced on 11.10.2016. All quarterly sprinkler reviews are attached. 4. The Maintenance Director, or designee, will schedule on 2017 calendar. Noncompliance will be reviewed monthly at Quality Assurance meeting until consistent substantial compliance has been met, or a minimum of three months. 12.15.16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445124	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BRANDYWOOD	555 E BLEDSOE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 5 NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, 9.7.1.1 (2012 Edition), NFPA 13, 26.1 (2010 Edition), NFPA 25, 5.2.1.1.2 (2011 Edition) 4. Document review on 11/7/16 at 10:08 AM, revealed the facility failed to provide the required documentation for the sprinkler quarterly's for 1st and 2nd quarter during 2016. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, 9.7.1.1 (2012 Edition), NFPA 13, 26.1 (2010 Edition), NFPA 25, 5.1.1.2 (2011 Edition) The Maintenance Director and the Director of Nursing were present when the deficiencies were identified and were acknowledged by the Administrator during the exit conference on 11/7/16.	K 353		
K 741 SS=D	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe	K 741		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445124	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BRANDYWOOD	555 E BLEDSOE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 741	Continued From page 6 design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the smoking areas: The findings included: Observations on 11/7/16 at 9:51 AM, revealed the self-closing device installed on the metal container used for emptying ashtrays was not working properly. NFPA 101, 19.7.4 (2012 Edition) The Maintenance Director and the Director of Nursing were present when the deficiencies were identified and were acknowledged by the Administrator during the exit conference on 11/7/16.	K 741	K 741 1. No residents were found to be affected. 2. The facility has determined that all residents have the potential to be affected. 3. New self-closing step-on can ordered on 11.08.2016. 4. The Maintenance Director, or designee, will monitor on daily rounds. Noncompliance will be reviewed monthly at Quality Assurance meeting until consistent substantial compliance has been met, or a minimum of three months.	12.15.16
K 914 SS=D	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at	K 914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445124	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BRANDYWOOD	555 E BLEDSOE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 7 intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is not met as evidenced by: Based on document review, the facility failed to maintain the electrical system. The findings included: Document review on 11/7/16 at 10:26 AM, revealed the facility failed to conduct the required annual retention force test of the grounding blade of each electrical receptacle located in the patient care areas. NFPA 99, 6.3.3.2.4 (2012 Edition) The Maintenance Director and the Director of Nursing were present when the deficiencies were identified and were acknowledged by the Administrator during the exit conference on 11/7/16.	K 914	K 914 1. No residents were found to be affected. 2. The facility has determined that all residents have the potential to be affected. 3. Annual retention force test completed on 11.18.2016. 4. The Maintenance Director, or designee, will monitor annual calendar. Noncompliance will be reviewed monthly at Quality Assurance meeting until consistent substantial compliance has been met, or a minimum of three months.	12.15.16
K 920 SS=D	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445124	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BRANDYWOOD	555 E BLEDSOE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 8 (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observations, the facility failed to comply with regulated use of power strips. The findings included: 1. Observation on 11/7/16 at 8:46 AM, revealed medical equipment was plugged into multi plug (surge protectors) adapters that did not meet the approved UL listings in the following areas: a. Room 102 (Bed A) b. Room 200 (Oxygen Concentrator) c. Room 301 (Bed) d. Room 406 (Bed and Oxygen Concentrator) e. Room 409 (Bed) CMS S&C 14-46-LSC 2. Observations on 11/7/16 at 9:00 AM revealed a multi-plug power strips providing power to a second muli-plug power strip in the following	K 920	K 920 1. No residents were found to be affected. 2. The facility has determined that all residents have the potential to be affected. 3. Facility audit of all electrical plugs and all unapproved multi-plugs immediately removed on 11.09.2016. 4. The Maintenance Director, or designee, will monitor annual calendar. Noncompliance will be reviewed monthly at Quality Assurance meeting until consistent substantial compliance has been met, or a minimum of three months. 12.15.16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445124	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BRANDYWOOD	555 E BLEDSOE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 9 areas: a. Room 301 b. Room 407 c. Medical Records office CMS S&C 14-46-LSC The Maintenance Director and the Director of Nursing were present when the deficiencies were identified and were acknowledged by the Administrator during the exit conference on 11/7/16.	K 920		